

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFERS

Provider/Physician Name

Provider/Physician ID Number

I hereby authorize _____, hereinafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries in error to my ☐ Checking ☐ Savings account (***select one***) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

Depository Name

Branch

City

State

Zip Code

Transit Number

Account Number

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Name *(please print)*

Title *(please print)*

Signature

Date

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the *Federal Register Privacy Act Issuances*, 1991 Comp., Vol. 1, Page 419 and Page 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.